Witness Name: Nicholas Archer

Statement No: 1

Dated: 28 August 2026

Rule 9 reference: Rule 9(1)

LAMPARD INQUIRY

WITNESS STATEMENT OF NICHOLAS ARCHER

SECTION A: Introduction

1. My name is Nicholas Archer. I am the Head of Deteriorating Patient Pathways responsible for leading on the development and implementation of strategies, to ensure the safe and appropriate management of the deteriorating patient. In addition, I am the Resuscitation Training Officer at EPUT. I have held these positions since May 2022. This is my response to a personal Rule 9 Request which was sent to me by the Lampard Inquiry on 11th August 2026.

2. In preparing this personal statement, I have drawn primarily on my personal knowledge and experience and on the Rule 9 materials provided to me. Whilst the period under consideration spans approximately 20 years, I can only answer for the period during which I have been employed. I have endeavoured to provide an accurate and honest account to the best of my knowledge and belief.

SECTION B: Background and Experience

3. I qualified as an Operating Department Practitioner (ODP) in 2006 (DipHE Operating Department Practice) and worked within the operating theatres of an acute Trust for a total of 19 years. As an Anaesthetic ODP, I regularly responded to both adult and paediatric medical emergency and cardiac arrest calls throughout the Hospital as part of the crash team. I also assisted the Anaesthetist, was involved in the inter and intra-hospital transfer of critically ill patients, and taught Resuscitation Council UK (RCUK) basic life support (BLS) to operating theatre staff.

4. I held the post of Matron for Theatres before leaving the Mid and South Essex NHS Foundation Trust to join Essex Partnership University NHS Foundation Trust (EPUT) as Head of Clinical Governance for the mass vaccination programme in May 2021. I commenced my current role in May 2022.

5. In terms of my resuscitation qualifications and instructor credentials, I gained my most recent RCUK Advanced Life Support (ALS) qualification in 2021 and progressed to become a RCUK ALS instructor in 2022. I have subsequently taught on a total of 22 RCUK ALS courses and two immediate life support (ILS) courses. I also completed a TALK Foundation supporting clinical debrief instructor course in 2022. In 2025, I gained RCUK Generic Instructor Course (GIC) full instructor status

and have subsequently taught on a total of six GIC courses. Also in 2025, I gained a PGCert in Medical and Healthcare Education (Anglia Ruskin University).

6. I have not worked on a mental health ward although I have spent time within various EPUT ward settings since joining. I have not carried out any specific nursing duties. I have never been involved in any resuscitation attempts on a mental health ward.

SECTION C: Current Role

7. The Head of Deteriorating Patient Pathways and Resuscitation Training Officer are dedicated posts and whilst separate in relation to their areas of responsibility, they are intrinsically linked, as appropriate recognition and management of a deteriorating patient may prevent the patient going into cardiac arrest.

8. Having responsibility for both roles provides me with a unique opportunity to advise on and inform change in both areas of practice. There are regularly competing priorities to manage, as I also lead on medical devices within the Trust. However, I am fortunate to have the support of Douglas Smale (Head of Clinical Transformation), a fellow RCUK ALS, ILS and GIC instructor, who provides support in relation to resuscitation and physical health training and advice. The provision of RCUK ILS training is currently outsourced to an externally RCUK accredited provider (A to E Training Solutions), whilst RCUK BLS training is currently provided in-house by the EPUT workforce training team. I am in the process of bringing the ILS training in-house.

9. As Head of Deteriorating Patient Pathways, I lead on the development and implementation of strategies to ensure the safe and appropriate management of the deteriorating patient. This includes sepsis management, the use of NEWS2 as an early warning tool, and the development of clinical patient pathways and associated medical equipment to support, monitor, prevent and manage clinical deterioration throughout the Trust. As the Trust's lead Resuscitation Training Officer, I oversee resuscitation training provision. In addition, I review the effectiveness of care processes to identify examples of good practice and areas for improvement, contributing to the Trust’s culture of learning.

10. On a daily basis, the roles require me to review relevant Datix incident reports and provide help, advice and support to operational staff as required, in relation to physical health and resuscitation matters. I am also responsible for carrying out reviews of allocated Policies and Clinical Guidelines as the named author, and for reviewing CCTV and Lio footage as part of patient safety investigations. I work closely with Douglas Smale to facilitate life support and physical health refresher sessions for staff. I also work closely with the EPUT workforce training team, who currently deliver RCUK BLS training and oversee the outsourced RCUK ILS training bookings and budget. In terms of governance, I chair the monthly Harm Free Care Group and feed into the bi-monthly combined Resuscitation and Deteriorating Patient and Medical Devices Group meetings, as well as other forums including the Falls Group, Learning Oversight Sub Committee, Learning Collaborative Partnership meeting and Learning from Deaths Oversight group. In addition, I ensure the medical devices team are fully supported. Following the creation of the Physical Health Faculty and the subsequent in-house delivery of RCUK ILS, I will regularly be delivering RCUK ILS as part of the faculty.

11. I currently have responsibility for the leadership of the medical devices team but not a team relating to resuscitation or physical health within the Trust. Since starting at EPUT, I created and formed the medical devices team, which consists of a medical device safety officer (MDSO) and dedicated administration support. I have monthly supervision meetings with the MDSO to ensure they are fully supported within their role.

12. I am Line Managed by Rebecca Pulford (Director of Nursing and Chief Nursing and AHP Information Officer). I am also accountable to Ann Sheridan (Executive Nurse).

13. I have formal supervision sessions with my Line Manager on a monthly basis, as far as possible, in addition to an annual appraisal. These supervision sessions provide a structured opportunity to discuss workload, ongoing projects, professional development and any concerns or challenges arising within my areas of responsibility. In addition to these formal sessions, I have regular informal catchups and ongoing communication with my Line Manager, which ensure that any emerging issues or priorities can be addressed in a timely manner. I feel well supported within my role and am confident that there are appropriate mechanisms in place to escalate matters, should the need arise.

14. Elements of my role such as pro-active and reactive teaching, mentoring, supporting and debriefing staff, require me to be physically present on an inpatient ward at times. I am present on the wards for a range of purposes, including delivery of life support sessions, co-facilitating medical emergency simulations (when requested), attending SWARM huddles and debriefs, providing support to staff following resuscitation events. The frequency of my presence on an inpatient ward will fluctuate depending upon demand and planned pro-active pre-arranged sessions. I can be on a ward 5 days a week, or once every three weeks, it is solely dependent on circumstances.

SECTION D: Application of RCUK Quality Standards

15. From a nursing perspective, my role within EPUT is defined as the Trust's lead Resuscitation Training Officer. My training clearly qualifies me as having 'active and credible involvement in resuscitation'. I am currently the only Resuscitation Officer.

16. I understand that Doctor Mateen Jiwani has the specialty of resuscitation, within their existing portfolio of responsibilities, as Chair of The Quality committee.

17. As an active RCUK ALS, ILS, BLS and GIC instructor, my skills and knowledge are both up to date and current. I also help co-facilitate medical emergency simulations on inpatient wards, as required and provide feedback to the operational team, via a learning conversation. My previous role as an Anaesthetic ODP, involved me regularly responding to both adult and paediatric medical emergency and cardiac arrest calls throughout the Hospital, as part of the crash team.

18. The Trust is extremely supportive in enabling me to implement change relating to both the recognition and management of the deteriorating patient and resuscitation. The following are examples of changes I have made:
    - The implementation of RCUK ILS to registered nursing staff, working within an inpatient setting.
    - The introduction of Laerdal portable suction devices to each site, following key learning identified from a SWARM huddle that I attended.
    - The inclusion of the UK Sepsis Trust sepsis screening tools within the EPUT Clinical Guidelines on the Use of National Early Warning Scoring System (NEWS2) CG87.

- The creation and implementation of the EPUT specific assessing a critically unwell patient, non-contact physical observations and calling (9)999 in a medical emergency documents.
- The provision of clear and concise escalation pathways in relation to NEWS2 (printed on the reverse of the NEWS2 chart).
- Production of a EPUT resus bag refresher film.
- Review and subsequent amendments relating to the CPR Policy, Clinical Guidelines on the Use of National Early Warning Scoring System (NEWS2) and Physical Health Clinical Guideline documents.

19. I currently have no budgetary input or involvement in setting budgets for the resuscitation service structure. The budgets associated to the delivery of both RCUK ILS and BLS currently sit within the EPUT workforce training team. I am not aware of how the level of financial support for the resuscitation service structure is determined, as this falls outside my area of responsibility.

20. I am aware that EPUT are in the process of recruiting two additional Resuscitation Officers posts, as part of the Physical Health Faculty. They are required to be qualified to master's degree level or equivalent experience, be a registered healthcare professional NMC or HCPC, hold a teaching qualification e.g. ENB998 or equivalent experience, have clinical debriefing experience, have experience of delivering clinical skills/resuscitation, hold ALS (Advanced life support) instructor qualification.

21. Whilst I am a Resuscitation Officer given that the Trust operates across 52 inpatient wards across a vast geographical area, it is not practicable for me to respond to or participate in cardiac arrest management in person. I do not respond to or participate in cardiac arrest management. However, as part of my role, I review relevant Datix incident reports daily and provide help, advice and support to operational staff as required, in relation to resuscitation matters. I also attend debriefs and SWARM huddles whenever required, to ensure that learning from incidents is captured and disseminated effectively. In addition, I offer life support refresher sessions following resuscitation attempts and provide a safe and supportive environment within which staff are encouraged to reflect on their experience, ask questions and discuss any concerns relating to resuscitation practice.

22. The response to any medical emergency will come from and be led by the ward team. As I am currently the only Resuscitation Training Officer within the Trust, covering 52 inpatient wards across a vast geographical area, it would not be practicable for me to attend a medical emergency in a timely manner, unless I happened to be present on the ward at the time of the incident. When I am not delivering face-to-face training to teams, I work from an administration space at either the Lodge in Wickford or Rivendell in Colchester.

SECTION E: Policy Changes

23. The principal changes I made to the CPR procedure CLP14 and the Clinical Guidelines on the Use of National Early Warning Scoring System (NEWS2) are recorded within the document review histories at page 2 of each document (Exhibits NA-1 and NA-2 respectively). In summary they are:
    - Reference to ESS training was removed as this life support training was superseded at the time of writing the Policy by RCUK ILS, grab bag and BLS training. There was a transitional period during which the move from grab bag to RCUK ILS training was taking place and as a result, some staff still received grab bag training during that time. Any reference to the Modified Early Warning Score (MEWS) was replaced by National Early Warning Score (NEWS2) as a direct result of NEWS2 being implemented within the Trust. NEWS2 superseded the preexisting MEWS that had previously been in use across the Trust.
    - The 'Definition of terms' section was reworded to reflect the addition of NEWS2 and RCUK ILS training.
    - The addition relating to the Duty Doctor in paragraph 4.1, was made to provide additional clarity regarding their role in a medical emergency, and a rationale for their early involvement was included.
    - Paragraph 6.8, which relates to the checking of the portable (CD size) oxygen cylinder, was added following a patient safety incident. A link to the EPUT internal alert (INT 2022 LL002) dated 08/08/2022, was added for signposting purposes.
    - Appendices 1-5 of the CPR Procedure were updated to reflect the revised RCUK guidance (2021 guidelines) which EPUT followed.

- Reference to role of The Head of Deteriorating Patient Pathways and Resuscitation Training Officer was made within the two documents, as this was a newly created role.

24. The RCUK quality standards for CPR (updated June 2020), Mental Health Inpatient Care (updated May 2020) and the Mental Health Inpatient Care Equipment and Drug Lists (updated May 2020) documents were reviewed and followed and referenced, at the time of the document reviews. As far as I am aware, there were no deviations or modifications from the standards.

25. National guidance, RCUK, National Institute for Health and Care Excellence (NICE), Care Quality Commission (CQC) and National Patient Safety Agency (NPSA) were also followed and referenced within the documents. As far as I am aware, there were no deviations or modifications from the national standards.

26. Reference was made to the relevant CQC, NICE and RCUK documents, as this was part of the rationale, for procuring the RCUK ILS training that supersedes the ESS and grab bag training, which was previously provided by the Trust. This information provides information for EPUT staff, as to one of the reasons why the change has been made.

27. At the time of reviewing the document, I was unaware that previous versions had wrongly referred to a requirement for basic life support training and was aware that prior to my employment with EPUT, ESS, grab bag and BLS training had been delivered to EPUT staff. The decision to move from grab bag to RCUK ILS training, was made to adhere to the, relevant CQC, NICE and RCUK guidance documents.

28. I am aware that the Executive Team had agreed to procure RCUK ILS training from the outsourced RCUK accredited provider (A to E Training Solutions) in July 2022 and training dates had been scheduled for September 2022. There was a period when the transition from grab bag to RCUK ILS training was taking place and as a result, some registered nursing staff, working within an inpatient, setting would still receive grab bag training. Following the transition period, all registered staff working within an inpatient setting would receive RCUK ILS training and all other staff would receive RCUK BLS training.

29. Paragraph 4.1 of the Procedure clearly states that the duty doctor must be informed and attend so that they can contribute to the resuscitation event. All duty doctors will be minimally trained to BLS and as such will be trained to use resuscitation equipment.

30. The requirement under NG10 for the doctor attending to be trained in resuscitation equipment is, and has always, incorporated into the procedure, see above. It should be noted that medical staff would be trained to a minimum of RCUK BLS which would include the use of an automated external defibrillator (AED). Medical staff may also be RCUK ILS, or advanced life support (ALS) providers and their specific training (depending upon their role) would enable them to safely use the emergency equipment contained within a resus bag or crash trolley, including the AED. Doctors must attend a medical emergency when onsite. There is also an out of hours on call service. Additional information is provided in the corporate statement.

SECTION F: Training

31. Responsibility for organising and overseeing resuscitation training within EPUT does not rest with me alone; it is managed by the workforce training team. I worked closely with the EPUT workforce training team, to create the business case for the delivery of the outsourced RCUK ILS training, assisting with the external training provider selection process and identifying the specific staff who were required to undertake the training.

32. The EPUT workforce training team have responsibility for ensuring staff complete their mandated RCUK BLS or ILS training and this training is captured on the EPUT staff training tracker. The team send out booking reminders as required.

33. Mandatory training compliance data is provided by EPUT workforce training team and is shared for presentation at relevant care group meetings. This data is also presented at the bi-monthly combined Medical Devices, Resuscitation and Deteriorating Patient Group meetings. A review of individual staff mandatory training completion should also form part of staff supervision sessions.

34. The monitoring of whether new or temporary staff are made aware of Trust policies and procedures does not fall within my remit. This would be monitored by the ward as part of the induction programme and the training department.

35. Registered nursing staff working within an inpatient setting, together with medical staff (depending upon their role), receive RCUK ILS training. Medical staff may also be RCUK ILS or Advanced Life Support (ALS) providers, and their specific training enables them to safely use the emergency equipment contained within a resus bag or crash trolley, including the AED. This enhanced life support training builds upon the staff member's pre-existing knowledge of anatomy and physiology, which is of particular importance given that certain equipment, such as oropharyngeal or nasopharyngeal airways and the supraglottic airway device, constitutes an invasive medical procedure and carries associated risks. An underlying knowledge of anatomy and physiology is therefore required to carry out a robust assessment prior to insertion and to undertake a subsequent review of the intervention. The A to E assessment process, which is taught during the RCUK ILS training, also requires an appropriate baseline knowledge of anatomy and physiology to carry out an accurate and thorough assessment.

36. However, it is recognised that in an emergency, any member of medical staff, whether agency, bank, or permanent, may find themselves in the position of a first responder, regardless of their substantive clinical role. In that context, it is considered that Immediate Life Support (ILS) training would be beneficial for all such staff, and indeed this is expected. However, I would not consider that ILS training is appropriate for non-registered staff, since the training requires an understanding of human anatomy and physiology, which is not a competency that can be assumed unless they have received such training elsewhere.

SECTION G: Simulations/CPR drills

37. Paragraph 12.4 of the Policy for Adult and Paediatric Cardiopulmonary Resuscitation (CPR) document dated March 2026 states" The Ward Manager, Matron or Service Manager/Clinical lead for each inpatient setting, will be responsible for ensuring that medical emergency simulations are undertaken every three months in the clinical environment. Each inpatient setting must record when a medical emergency simulation is facilitated, using the approved 'Medical Emergency Simulation Practice Report' document". The Practice Nurse Educators

(PNE's) who are assigned to the inpatient and/or the Resus/ Physical Health Link Practitioners often facilitate or oversee the medical emergency simulations. This requirement is also documented within the EPUT Internal Safety Alert (INT GEN 25 006 – SWARM early learning (Resus) dated 23 June 2025.

38. I have worked closely with Doug Smale (Head of Clinical Transformation) to help formulate a suite of medical emergency simulations for the teams to facilitate. In addition, we have delivered a workshop, to support staff who will be facilitating the medical emergency simulations, on inpatient sites. I have both attended and co-facilitated several medical emergency simulations on the ward, as part of focused refresher sessions and have participated in the learning conversations. I also review and evaluate any Medical Emergency Simulation Practice Reports which are sent to me, and I always provide feedback to the sender.

39. It is recommended that medical emergency simulations are conducted on an unannounced basis, to provide a more realistic outcome. However, both announced and unannounced approaches are acceptable, for example if you are focussing training on a particular part of the response that may be more appropriately dealt with as an announced simulation/workshop. The importance of regularly facilitating medical emergency simulations is emphasised during life support refresher sessions, and it is acknowledged that there may never be an ideal time to conduct them. Notwithstanding this, there are significant risks associated with not practising both the technical and non-technical skills required for the resuscitation of a patient, and the benefits of regular practice far outweigh any short-term operational inconvenience.

40. Having reviewed the Medical Emergency Simulation Practice Reports which have been sent to me, it is apparent that teams are facilitating the medical emergency simulations at various times during the day/night and at weekends, to involve as many different staff as possible.

41. All staff members, regardless of their role or employment status are expected to attend, whilst recognising that the inpatient facility needs to remain safe.

42. There is no written requirement as to how many medical emergency simulations each staff member must attend on an annual basis.

43. The process for facilitating a medical emergency simulation comprises the following stages:

- The facilitator will select a suitable date, time and venue for the simulation in advance and ensure that the required resources are available (e.g. a training CPR manikin and training resus bag). A medical emergency simulation scenario will be chosen from the shared library of resources, and any additional support required (e.g. additional helpers to facilitate the simulation) will be identified.
- A final set-up, environment and equipment check will be carried out prior to the facilitator raising the alarm. This may be done by calling for help or activating the emergency alarm (e.g. a pinpoint device).
- The facilitator will either run the medical emergency simulation in its entirety or choose an appropriate point at which to end it. Coaching, mentoring and advice may be provided by those facilitating the simulation, and there is also the option to pause or stop, depending on the progress of the simulation.
- Upon completion, the simulation will be followed by a learning conversation, which enables the facilitator to gain an understanding from both the team leader and their supporting team as to how they felt during the simulation, whilst also providing an opportunity to share key learning points.
- The facilitator will then clear up and repack the training resus bag and manikin.

44. The facilitating team will monitor and assess the medical emergency simulation as it is delivered. The Medical Emergency Practice Report document is used to record the medical emergency simulation and can be completed contemporaneously.

45. I do not have the data to confirm whether each ward is carrying out an emergency simulation as required by the CPR Policy. To address this gap, as of August 2026, a specific audit question has been added to the Ward Managers (inpatient) Tendable audit, requiring confirmation as to whether a medical emergency simulation has been carried out within the preceding three months. This will enable compliance to be monitored on an ongoing basis going forward.

46. To date, and as far as I am aware during my tenure, whilst there is an immediate opportunity to change exiting practice, as a result of the learning conversation which follows each medical emergency simulation, there have not been any specific Trust wide changes to practice, policy or procedure, which have taken place as a direct result of a medical emergency simulation. The learning conversation process does, however, ensure that immediate and ward-level improvements can and do occur, even where those improvements have not yet resulted in a formal policy or procedural change at Trust level.

47. In my opinion, there is significant benefit to be gained from teams actively engaging in medical emergency simulations, as they provide a valuable opportunity to practise both technical and non-technical resuscitation skills in a safe and supportive environment, with the provision of mentoring, coaching and key learning points following the learning conversation. This 'little and often' approach is essential in order to consolidate and refresh the learning and skills gained during the RCUK ILS classroom-based training. By way of example, positive feedback has been received from two teams who have each managed a medical emergency differently, as a direct result of the learning gained from a medical emergency simulation that they had either observed or participated in.

48. I cannot speak to the entire period under review; however, since joining the Trust, Doug Smale and I have delivered workshops to support those staff who will be facilitating the medical emergency simulations, which I do not believe were offered previously. In addition, issues such as high ward acuity, staffing shortages, unavailability of a training resus bag or manikin or the fact that staff were unaware that a medical emergency simulation had not taken place within the past 3 months, could all be reasons as to why a medical emergency simulations have not taken place. Each site now has access to a dedicated training resus bag and manikin, which I believe were put in place just before I commenced my employment with EPUT. Historically, a member of the workforce training team would attempt to facilitate a medical emergency simulation (which was then referred to as a 'drill') using their own training equipment, once a year and teams would have to request access to training equipment, to facilitate two additional 'drills'. This could potentially be another reason, as to why 'drills' did not take place regularly. Whilst medical emergency simulations are an essential activity, it is important to note that in "2023-24, the overall survival of adult in-hospital cardiac arrest to discharge was

25.8%" (Resuscitation Council UK, 2025). Therefore, there needs to be a focus on the deteriorating patient, to prevent cardiac arrest occurring where possible.

49. To facilitate medical emergency simulations on a regular basis, there needs to be a sustained commitment from each ward, driven and fully supported by the senior leadership team and executive colleagues. This may involve training additional staff to facilitate the medical emergency simulations and establishing a structured process for scheduling and delivering them. A review of the medical emergency simulation reports at local ward-level meetings would be of significant benefit, to provide assurance and identify key learning points for wider dissemination.

50. The presentation of Tendable audit compliance data, together with a summary of key learning points identified during the learning conversation, at the appropriate care group meeting would provide the senior leadership team with the necessary oversight and assurance that medical emergency simulations are being facilitated regularly and in accordance with the requirements of the CPR Policy.

51. I was not aware of the lack of medical emergency simulations on Willow ward. Unless the medical emergency simulation practice reports are shared with me or the concern is escalated to me directly, I would have no visibility as to whether a lack of medical emergency simulations had occurred on any particular ward, including Willow ward.

52. As noted above, this has now been addressed by the audit amendment referred to above. A specific question added to the Ward Managers (Inpatient) Tendable audit, requires confirmation as to whether a medical emergency simulation has been carried out within the preceding three months. This provides a structured and auditable mechanism through which compliance can be monitored, any shortfalls identified at an early stage, and appropriate assurance provided on an ongoing basis.

SECTION H: Emergency Response/Resuscitation Incident on Mental Health Wards

53. Neither before nor since joining EPUT have I been involved in an emergency response to a deteriorating patient and/or a resuscitation event on a mental health inpatient unit.

54. Within my role, information relating to emergency responses and resuscitation events is initially gained, by accessing the Datix Incident Report Form and reviewing the Resuscitation Event Report Form. Further information can be gained by attending the SWARM huddles and debriefs.

55. The Resuscitation Event Report Form is attached to the Datix Incident Report, and each SWARM huddle is documented, providing a permanent record. I am unsure if debriefs are documented.

56. Since joining the Trust, Information gained from SWARM huddles has been used to make informed changes and improvements to emergency equipment provision. By way of an example, following a SWARM huddle, it was identified that a handheld suction device was used during a resuscitation attempt, however, staff reported that they found it difficult to remove fluid from the mouth, due to the sheer volume of fluid present. As a result, each inpatient site now has access to a Laerdal portable suction device, which has a high vacuum capacity and flow rate, making it effective in clearing airways.

SECTION I: Learning From Past Incidents

57. The Trust has demonstrated a clear willingness to respond to and implement changes following an emergency response or resuscitation event, as illustrated by the changes identified above. Such changes are not limited to the dissemination of learning; they may also encompass modifications to emergency equipment provision, revisions to clinical procedures and escalation pathways, and physical or operational changes to the ward environment. The mechanisms through which areas for improvement are identified include patient safety investigations, debriefs, SWARM huddles, Datix incident reports, staff escalations and information received from emergency service responders.

58. In terms of the process for implementing change, proposals are taken to the combined Resuscitation and Deteriorating Patient and Medical Devices Group meetings for discussion and approval, before being presented to the Harm Free Care Group for final approval. Whatever the proposed change, I work closely with the Lessons and Trust communication teams, as well as operational colleagues including members of the senior leadership team, Practice Nurse Educators,

resuscitation and physical health link practitioners, the transformation team and quality improvement colleagues to ensure effective implementation. Once approved, changes are shared Trust-wide through a range of established communication channels, including Wednesday Weekly bulletins, 'ticker' messages on Trust IT devices, the Lessons team's five key messages, the Lessons Identified newsletter, safety learning alerts and lessons briefings. Where a change is deemed to be significant and requires additional support to achieve sustainable implementation - for example, bringing RCUK ILS training internal, that support has been provided. Post-implementation monitoring is undertaken through staff feedback via QR code surveys, escalations, Datix incident reporting form submissions and reviews of SWARM huddle and patient safety incident documentation. Thereby ensuring that changes are embedded effectively and any further issues are identified at an early stage.

59. Since joining EPUT, I have not experienced any barriers to the implementation of change, whether in relation to equipment, clinical practice or procedural matters. On the contrary, I have been positively encouraged to implement change in relation to patient safety on a significant number of occasions, with consistent support from my Line Manager, Directors of Nursing and Executive colleagues.

60. In respect of question 14, I am unable to comment on individual cases which occurred prior to my joining EPUT. To the extent that those incidents have occurred during my tenure and fall within my knowledge, I can confirm that my position is as set out in the Corporate Statement, to which I have contributed. I wish to make clear that I am aware of my ability to provide a response which differs from that of the Trust; however, my own position is aligned with that of EPUT, and the Inquiry is accordingly referred to the Corporate Statement.

61. It is recognised that human error cannot be entirely mitigated, particularly in the context of medical emergency situations, which are inherently high-pressure and emotionally demanding. Such conditions present significant challenges to staff at all levels, and it would be unrealistic to expect that errors will never occur.

62. A further compounding factor is the infrequency with which many staff members are exposed to medical emergency scenarios in the course of their day-to-day duties. Limited exposure of this nature can adversely affect the ability of staff to respond effectively and may result in failures to follow established processes and

procedures, or to apply skills and knowledge that would otherwise be available to them.

63. Central to the effective management of a medical emergency, including cardiac arrest, is the role of the team leader. This role is afforded considerable emphasis within the Immediate Life Support (ILS) training programme delivered by the Resuscitation Council UK (RCUK). The Resuscitation Council UK has stated that: "A team leader provides guidance, direction and instruction to the team members to enable successful completion of their stated objective." The importance of effective team leadership in such circumstances cannot therefore be overstated, and the adequacy of training, preparation and support provided to those expected to fulfil this role is a matter of significant relevance.

64. The vast size and geographical spread of the Trust, the number of substantive, bank and agency staff, and the demands of inpatient clinical workloads present an inherent challenge to the effective dissemination of important safety information to frontline staff. This is compounded by the potentially limited opportunities that operational staff have to access electronic communications during their shifts. To mitigate this, the Trust has established a dedicated Lessons team, the Learning Collaborative Partnership and the Learning Oversight Committee, which together support the sharing of lessons and learning through a range of established channels, including Wednesday Weekly bulletins, five key messages, the Lessons Identified newsletter, safety learning alerts and lessons briefings.

65. I do not consider that the recurrence of broadly similar themes necessarily indicates that learning was not identified or that action was not taken. The actions taken when learning from incidents frequently resulted in changes to training, equipment provision, escalation processes, documentation and communication systems. However, in my view, the greater challenge is ensuring that those actions are consistently embedded, maintained and assured across all inpatient settings over time. As demonstrated by the incidents identified by the Inquiry, implementation of remedial measures following one incident did not always prevent similar issues arising subsequently.

66. In my experience, a number of factors may contribute to this, including the matters set out in paragraphs 61-64 above. In those circumstances, a policy change,

learning bulletin or safety alert may not, by itself, ensure that all staff can confidently apply that learning during a high-pressure emergency situation.

67. It is equally important that the cascading of safety information, updates and learning takes place at a local level, to ensure that all staff are regularly informed and afforded the opportunity to raise questions and contribute suggestions aimed at improving patient safety.

68. Whilst I cannot comment on incidents that occurred before I joined EPUT, the information available to me suggests that recurring themes have arisen not because learning was absent, but because sustaining and assuring the consistent implementation of that learning across a large and geographically dispersed organisation is inherently challenging and requires ongoing reinforcement through training, simulation, audit and local leadership.

SECTION J: Recommendations

69. The Trust has made considerable progress in developing its approach to resuscitation and, in my assessment, is now positioned at the leading edge of practice in this area within the mental health sector. Douglas Smale and I are both active members of forums relating to physical health and resuscitation within mental health services, and have shared several documents, which we have developed and implemented within EPUT, with other Trusts who recognise the potential patient safety improvements that such resources can provide.

70. Drawing upon my experience within this role and informed by the relevant national guidance, I make the following recommendations with a view to enhancing patient safety in mental health inpatient settings, with particular focus upon the identification and management of the deteriorating patient and resuscitation.

71. The RCUK Quality Standards: Mental health inpatient care (May 2020) requires each organisation to have an identified board member responsible for resuscitation services, as originally mandated by Health Services Circular 2000/028. I would recommend that EPUT goes further by nominating a member of the medical team as a designated medic aligned to the resuscitation service, with this function clearly specified within their portfolio of responsibilities. The designated medic should

have a demonstrable interest in the identification and management of the deteriorating patient and resuscitation and should attend the bi-monthly Resuscitation and Deteriorating Patient Group meetings, co-review the CPR Policy, and participate in post-resuscitation SWARM huddles and debriefs. This addition would bring greater clinical depth to the existing governance structure and strengthen the advice and support available to the resuscitation service.

72. I would recommend the development of a robust, locally owned structure on each inpatient ward, driven by the senior leadership team, to ensure that medical emergency simulations are facilitated in accordance with the frequency stipulated in the CPR Policy. Regular simulation practice is essential to maintaining confidence and competence in both the technical and non-technical skills required for resuscitation and provides a valuable opportunity for equipment familiarisation. The key learning points arising from the post-simulation learning conversations should be discussed at local ward-level meetings and escalated to the relevant care group quality of care meeting, to provide oversight and enable wider dissemination of good practice. I would further recommend that the role of simulation in improving resuscitation outcomes within mental health settings be explored at a national level, given the significant body of research supporting its efficacy.

73. There appears to be a significant gap in physical health training for nursing staff working within mental health settings, which may be attributable to historic training provisions at a national level. Whilst there is a documented drive to reduce health inequalities between mental and physical healthcare (NHS Health Education England, 2020), I do not consider that this is yet being adequately reflected in the training provided to staff in mental health inpatient settings. I would recommend that a structured physical health training package be embedded within pre-registration mental health nursing programmes and subject to regular refreshment thereafter. An equivalent training package should also be available for non-registered staff. Within EPUT, we will be trialling the implementation of the NHS Health Education England 'Physical health competency framework for mental health and learning disability settings' (2020) in conjunction with the NHS England 'Bite sized teaching' modules, and I consider that the adoption of these resources would be of significant benefit to all staff working within mental health inpatient settings. I would recommend that mandated physical health training for mental health staff be explored at a national level.

74. Given the limited exposure that staff in mental health settings have to physically deteriorating patients, annual training in the identification and management of the deteriorating patient is, in my view, essential. This training should be provided to both registered and non-registered staff, recognising that it is frequently the non-registered staff who are tasked with undertaking physical health observations and completing the NEWS2 chart. Within EPUT, we are in the process of making this training essential to role for all staff working within an inpatient setting, and I would recommend that this be explored at a national level as a mandated training requirement.

Statement of Truth

I believe that the facts stated in this witness statement are true to the best of my knowledge and belief.

Signed:

[I/S]

Dated: 1st September 2026